VERMONT STATE HOSPITAL FUTURES PROJECT
VERMONT DEPARTMENT OF MENTAL HEALTH

Certificate of Need Implementation Report for Docket #06-013-H

Project Overview

The Futures Plan is Designed to Transform the System of Care

The Futures Plan calls for the continued transformation of the service system towards a consumer-directed, trauma-informed, and recovery-oriented system of mental health care. The core of the plan is proposed new investments in the essential community capacities, along with reconfiguration of the existing 54-bed inpatient capacity at the Vermont State Hospital into a new array of inpatient, rehabilitation, and residential facilities for adults. In FY 09 $7.2M was proposed by the Administration and appropriated by the Legislature for an array of community services. These included: community residential recovery services, recovery housing support, peer services, inpatient diversion beds (crisis beds), alternative transportation services, and consultation services for development of the care management system and treatment program planning for the proposed secure residential facility. Level funding for these services is proposed in the current administration proposals for FY10.

The fundamental goal of Futures is to support recovery through provision of trauma informed treatment programming for Vermonters with mental illnesses in the least restrictive and most integrated settings. To this end the Department of Mental Health was granted a Conceptual Certificate of Need in April 2007 to proceed with a comprehensive planning effort to define the successor facilities of the Vermont State Hospital.

Framework of the Futures Strategic Plan

The following core recommendations follow from the Futures Strategic Plan that emerged from the planning process conducted during 2007.

1. In order to reduce reliance on involuntary inpatient services, Vermont should create new community residential, rehabilitative, and support services targeted to people with severe mental illness. All Vermonters at risk of psychiatric hospitalization potentially benefit from these services.

2. The long term care and rehabilitative functions currently performed at VSH could be better accomplished in non-hospital settings, including smaller, residential rehabilitative programs. This could improve rehabilitative outcomes in a cost effective manner.

3. The remaining acute inpatient services at VSH should be integrated with existing acute care psychiatric inpatient programs operated by general medical centers. This requires new types of inpatient programming at general hospitals and therefore requires appropriate infrastructural supports for the psychiatric inpatient program(s).

Function and Current Status of the Vermont State Hospital (VSH)

VSH provides a statewide service for Vermonters with severe mental illness, virtually all of whom are there under conditions of involuntary commitment. This population represents the most acute admissions of the entire system and the most refractory in terms of achieving treatment progress. As a consequence, they have comparatively longer lengths of stay when compared to patients served by Vermont's other hospitals offering inpatient psychiatric services. Currently, VSH is the only hospital authorized to administer non-emergency involuntary medication.

The Vermont State Hospital is licensed for 54 beds. During 2006 and 2007 the average daily census hovered around 50 – 52 patients. Since the opening of Second Spring, Vermont's first community recovery residence, in 2007, the average daily census at VSH has fallen. The average daily census for 2008 was 44.6. During the period October 2008 to April 2009 the VSH average daily census was 45.4. The high during this time was 51, the low 40. The constancy of the data suggests the opening of the Williamstown facility continues to impact the VSH census in the desired direction.

The Governor's recommended operating budget for VSH in fiscal year 2010 is $23.3 million. Over the past several years the Agency of Human Services has invested new resources to improve the existing program. These augmented resources followed in part as the consequence of an agreement with the Department of Justice to improve services at Vermont State Hospital. Among these are upgraded capacity in Information Technology, contracted services in quality improvement and training and education, and creation of 60 new clinical and management positions. Funds were also provided for the development of a Treatment Mall in a newly renovated space with programming designed to provide 20 hours per week of active treatment (skills development, groups, and individual treatment plans focused on recovery). As reported in the October Implementation Report the Department anticipated that these improvements would advance CMS re-certification and thus Medicaid funding for VSH.

The Treatment Mall opened during the Fall of 2008 but was closed in November following the finding by CMS that exposed pipes below the ceiling constituted a safety hazard. The Department, while appealing the finding, has requested funds in the FY 10 Capital Bill for cost of remediation. The Treatment Mall remains closed until renovations are complete. Programming continues in an alternate space. (See below: Application for CMS Certification.) By closing the Treatment Mall the Department can request CMS to reconsider its findings.

Joint Commission accreditation: As noted in the October 2008 Implementation Report, VSH received accreditation from the Joint Commission. Accreditation of VSH is a critically important step in the State's comprehensive Futures Plan to revitalize Vermont's mental health system.

Application for CMS Certification: DMH applied for certification from CMS in 2008. The State objective was to regain CMS certification by the end of the year. CMS regulators visited VSH during the week of September 15, 2008, to conduct a 4-day site inspection. Their written site report cited concerns with patient rights, facility, and policy, and recommended the program not be recertified. DMH has requested a reconsideration of the CMS findings in order to have the opportunity to present and implement a plan of correction to address the concerns cited in the review (See discussion of Treatment Mall above).

Department of Justice Site Evaluations: The Department of Justice conducted its 5th monitoring site visit at VSH during the week of October 6, 2008. Findings of this visit were that VSH continues to make significant improvements in many areas including treatment planning, mental health assessments, discharge planning and community integration, incident management and quality improvement. The hospital was scored as being in significant compliance with 85% of the 9 areas studied in the report. This was the second consecutive report that found no area where VSH was non-compliant with DOJ's previous recommendations. The report is located on the DMH website: http://healthvermont.gov/mh/programs/hospital/documents/DOJ_Report_01.09.09.pdf

VSH is proceeding with implementation of the 3-year, $214,000 / year grant to reduce use of seclusion and restraint. The grant objectives include implementation of a hospital wide strategic plan that builds on SAMHSA's 6 core strategies for reduction of seclusion and restraint (S&R). In November VSH hosted a 2-day training on strategies for promoting recovery and avoiding seclusion and restraint procedures. Some 300 people from 6 states attended. Current implementation activities include VSH patient-staff community meetings to discuss ways to improve the culture of the units and avoid the use of S&R. A stakeholder advisory council convened last summer and is now working with the S&R project coordinator to review data on incidents of S&R. The advisory council is one of the 6 core strategies, and is designed to develop an evidence-based approach to understanding and evaluating implementation.

Although the hospital has made significant gains toward improved quality of care in compliance with the Department of Justice standards, the physical space of the building does not support the clinical mission of VSH. There is virtually unanimous agreement among stakeholders that the physical facility should be closed. Determining the number and kind of services that should constitute the successor facilities is the object of this Certificate of Need planning process.

Current Situation

Building on the results of its 2007 Inpatient Options Analysis, and in concurrence with the Legislative Consultants, DMH continues to move forward with plans to replace some

of the functions of VSH through construction of a 15-bed residential recovery (SRR) facility on the grounds of the State Office Complex in Waterbury. The Department is engaged in fruitful negotiations with Rutland Regional Medical Center to develop 12 VSH level inpatient beds as part of the hospital's proposed new psychiatric unit. In addition, planning is underway for the development of a 6 bed staff secure community residential recovery program in Brattleboro (Meadowview). In keeping with these activities, the FY'10 Capital Bill proposed by the Douglas administration, requests funds to complete the planning efforts for the SSR and Rutland project.

Renovation of the Treatment Mall
The Department has requested $400,000 in FY '10 funds to supplement funds appropriated in FY'09 to continue Vermont State Hospital renovations and to support facility improvements deemed necessary for the VSH re-certification effort. This includes the mitigation of issues raised by CMS. It is expected that the FY10 appropriation will permit the State to complete work begun last year.

Planning for the 15-Bed Secure Residential Recovery Facility (SRR)
The Department has completed the Inpatient Options Analysis of 21 sites configured in 5 models and has focused planning efforts on a distributed model that includes the SRR. Further analysis of the Waterbury alternative site options for the SRR has also been performed. See discussion below (Objectives 1 & 2). DMH has requested $500,000 in FY'10 capital funds to continue the process of planning, designing and permitting the 15-bed SRR.

Planning for VSH Level Beds - Rutland Regional Medical Center (RRMC) Psychiatric Inpatient Expansion
DMH has also requested $250,000 in FY'10 capital funds to continue the planning process with RRMC. The State and RRMC have been exploring a collaboration agreement detailing ownership and programmatic operations of a potential new program to expand the acute intensive psychiatric care at RRMC to 25-29 beds. Of these, some 12 beds would serve VSH level patients. The planning funds will allow the State to continue the exploration of the collaboration agreement as well as provide the State's share of the expenses for continued planning, design and permitting for the proposed facility. (See Objectives 1 & 2 below.)

Current Timelines for CON Application – Request for Extension
As the prior Implementation Reports reflect, DMH has made significant progress in the planning and implementation of a number of elements of the Conceptual Certificate of Need and of the Futures Plan. However, work remains. Pending legislative action on the Capital Bill for 2010, DMH anticipates filing a letter of intent for a Phase II CON for the Secure Residential Recovery facility on or before November 1, 2009. Following that, DMH anticipates that it will be a co-applicant on a letter of intent for a CON application with RRMC on or before June 1, 2010. These revised timelines were included in the March 25, 2009 letter to BISHCA requesting an extension of or an amendment to the Conceptual Certificate of Need that will expire April 12, 2009. On March 31, 2009 BISHCA responded to this request by granting a 12 month extension premised on the

filing of a letter of intent for the Secure Residential Recovery Program on or before November 1, 2009. The letter further instructs DMH to seek an amendment to the Conceptual Certificate of Need as DMH plans become more concrete.

Work Plan Progress

Benchmark Objective 1: Assess inpatient configurations based on feasibility analysis of multiple options—for both integrated and stand-alone facilities (CCON Conditions 13,15,17,18) See related Benchmark Objective 5.
Benchmark Objective Tasks: 1.1 –1.5

The four analytic Tasks 1.1 – 1.4 of this Objective are complete. The Inpatient Options Analysis will be incorporated as appropriate in supporting documentation for the CON application process for VSH successor facilities.

As described in the October 2007 and 2008 Implementation Reports, the preferred configuration emerging from the Draft Inpatient Options Analysis was that of Model 5 – consisting of new construction of a 15-bed secure residential recovery facility (SRR) in Waterbury and, pending further analysis and agreements with potential partner hospitals, an expansion at Rutland Regional Medical Center (RRMC), and possibly an expansion at Fletcher Allen Health Care Health Care. The underlying assumptions of this configuration assumed that lower inpatient bed capacity would be feasible with the development of additional community residential resources at successively staged levels of program intensity (Work Plan Objectives 10.1 – 10.6).

Policy implementation of the findings of the Draft Inpatient Options Analysis was understood to be dependent upon agreement among the Administration, the Legislature, and Fletcher Allen Health Care Health Care and RRMC, the potential partner hospitals. The November 2007 Report of the Legislative Consultants concurred with the draft findings of the Draft Inpatient Options Analysis (See Objective 2.6).

Considerable progress has been made in developing community residential and crisis services to help replace VSH functions. Replacing the acute inpatient functions of Vermont State Hospital has proved more challenging. Perhaps the most straightforward approach, building a new state operated facility of a similar size to VSH, has significant draw backs.

- Due to the complex medical co-morbidity and evolving treatments for acute psychiatric illness the best clinical models for acute psychiatric inpatient care are based on integration with general hospital medical care.
- Planning analysis indicates that Vermont needs 25-30 acute inpatient beds; not the current licensed capacity of 54 beds at VSH.
- The relatively small scale of acute care bed need makes creating a stand alone hospital (as opposed to a program within a larger hospital) extremely costly.
- The longstanding federal policy prohibiting Medicaid and Medicare reimbursement for care delivered in stand-alone psychiatric institutions (the

Institute for Mental Disease or IMD exclusion) increases the operating cost to the state.

DMH initially sought to create a primary inpatient psychiatric program with Fletcher Allen Health Care Health Care along with one or two small scale inpatient programs at other facilities to achieve geographic balance. A new facility operated by Fletcher Allen Health Care Health Care and located on its Medical Center Campus in Burlington has been ruled out due to cost. Fletcher Allen Health Care Health Care reports that they remain interested in operating new capacity. The most viable option appears to be development of new VSH-level beds with a larger inpatient replacement project that Fletcher Allen Health Care Health Care may undertake in the future. DMH has presented a draft framework agreement to Fletcher Allen Health Care Health Care and has requested that they model developing up to twenty (20) new acute care psychiatric inpatient beds with the larger facility master plan. It is unlikely that any such development can occur before 2015.

The 2008 Legislature enacted changes in the configuration of correctional facilities, resulting in closure of the women's correctional facility in the Dale Building on the property of the State Office Complex in Waterbury. The potential availability of the Dale space raised the possibility that Dale could be renovated to become the location of the 15 bed secure residential treatment facility. Accordingly, a second iteration of site assessment involving the Model 5 configuration was carried out over the summer and fall. BGS directed its consultants, Architecture+, to develop site sketches and construction cost estimates based on a common program of space for renovation of Dale, Brooks and the alternative of new construction. Based on the findings of this work, the administration is proposing construction of a new facility on the grounds of the State Office Complex in Waterbury. The design sketches, construction cost estimates and architectural assessments of pros and cons of each site option were reviewed by stakeholder groups and members of the Legislature during the fall of 2008. Information on all options considered will be included in the supporting information for the CON application.

Due to all these factors DMH has focused planning efforts on a more distributed model for developing replacement facilities for acute inpatient care. The Department is now seeking legislative support for this approach. See Project Overview above (p.4) on DMH request for legislative approval for funds to continue planning.

Benchmark Objective 2: Select Model & Site for CON Application (from 5 Models – 21 Sites)

Benchmark Objective Tasks 2.1 - 2.12.

2.1 Review findings of Inpatient Options Analysis Report.

This task for the Secretary of AHS to review the findings of the Draft Inpatient Options Analysis Report has been completed. Additional review of the results of the second iteration of the planning process occurs as products are developed.

2.2 Assess bed need for inpatient and residential services

This task continues in process.

With the opening of the Second Spring community residential program in May 2007, the average daily census of VSH declined. Second Spring admissions came from VSH. As noted above, the lower census rate has been more or less consistent during the past 6 months, averaging around 45 beds. This decline suggests that increased community residential resources will further lower the VSH census. The Futures Project envisions four levels of care needed to replace the current functions of the Vermont State Hospital: acute inpatient, secure recovery residential, staff secure intensive residential, and community recovery residential.

As reported in April 2008, DMH conducted a retrospective survey of VSH bed utilization during the winter of 2008. The study documented that less than 50 inpatient acute care beds are needed provided there is in place an array of residential beds of differential intensity. The next reductions in VSH census are expected to come from implementation of:

1. the expansion of Second Spring from 11 to 14 beds (achieved during the summer 2008) = 3 beds
2. the development of the secure residential recovery facility = 15 beds (requires CON)
3. the development of the staff secure recovery residence (DMH is currently reviewing an application for a Certificate of Approval submitted by *New Perspectives for Care*, a partnering entity between Health Care and Rehabilitation Services of Southeastern Vermont (HCRS) and the Brattleboro Retreat) = 6 beds.

Assuming successful development of the two new facilities, it is anticipated that the system will require 25-30 acute psychiatric inpatient beds to replace the remaining beds at VSH. (Note: For planning purposes it has been assumed that approximately 50 beds would be required to replace all functions of VSH; planning clearly requires the importance of continued analysis about the relative numbers of community and inpatient beds required.)

2.3 Develop report of how other states' facilities & programs (including systems in place or planned) serve populations similar to those served by VSH (CCON Condition 16)

This task has been completed.

As reported in April and October 2008, through in-depth interviews of commissioners and directors of state mental health authorities across all regions of the United States, the

Vermont Department of Mental Health researched and analyzed issues associated with reconfiguration of state hospitals. Questions concerned the role of state hospitals in the system of care, the role of general hospitals, the interrelationship of the hospitals with community services, architectural trends and building plans, financial considerations, and mental health services for special populations. During summer 2008 additional information on other state experience with structured residential facilities was obtained to inform the planning process for the 15-bed secure residential recovery treatment facility.

2.4 Assess revenue potential, long-range cost to state, capital construction & financing options, fiscal sustainability of mental health system as a whole (CCON Conditions 15 & 17)

This task is in process. Initial assessments were made as part of the work of the first iteration of the Draft Inpatient Options Analysis (Summary Report Submitted to the Mental Health Oversight Committee, November 2007). Cost estimates for the options for the proposed 15-bed secure residential recovery facility have been refined to better compare the 3 proposed sites at the Waterbury Complex. More detailed cost estimates suitable for development of construction design documents awaits approval of planning expenditures contained within the current Capital Bill for FY 10.

In line with these assessments and in the context of available resources, the Administration's FY10 proposed budget included level funding for the care management system, community crisis bed/step-down programming and an additional 6–10 beds for staff secure community residential intensive programming. The Administration also proposed to maintain funding levels for Second Spring, peer respite residential support programming, alternative transportation and supportive housing.

2.5 Obtain feedback from Transformation Council and other stakeholders on model / site trade-offs (CCON Condition 19). See Objective 3 below.

The tasks of this objective have been met and are ongoing.

Transformation Council The Council meets monthly, usually with 15-25 individuals in attendance. Since its inception, the Council has provided policy input on the various planning processes and products of the Futures Project. See Objective 3 below for a more detailed description of agenda items for the current reporting period. A list of Transformation Council Members was attached to the April 2008 report.

Consultation Group This is an advisory body to the Futures Project staff established in December 2007. The group met every 6 weeks through January 2009 to provide direct consumer and family member feedback to the project planning staff on current work products. DMH will convene new advisory groups to help inform planning and implementation as this work unfolds around. DMH is currently conducting interviews with current VSH patients to obtain their thoughts on ways to develop programming and architectural design consistent with the goals of recovery in the proposed SRR facility.

2.6 Integrate recommendations of Legislative Consultants

This task has been completed.

Obtaining agreement among key stakeholders and legislators is central to advancing planning for these successor programs. The Department regularly submits briefings on Futures planning to members of the legislative committees of jurisdiction.

2.7 Review findings of other states' experience in serving populations similar to VSH patients (CCON Condition s 15 & 16, Scope of Implementation Item 19)

Note: This task is same as 2.3 above and, its goals accomplished, has been removed from the Work Plan.

2.8 Review Futures Work Group recommendations & findings from Legislative Summer Corrections Study Group. Review findings of work group on the inpatient mental health treatment needs of the DOC inmate population. (CCON Condition 14)

This task has been completed. Results of the work group on Department of Corrections inpatient bed needs has been incorporated into planning for an inpatient Certificate of Need Application.

2.9 Review findings, reports with Transformation Council & other stakeholders; obtain feedback, and consult with Legislature. (See Objective 3 below)

This task is on-going. See Tasks 2.5 and 2.6 above and Objective 3 below.

Consistent with the findings of the legislative consultants (2007) the administration support the phased implementation of the Futures Project beginning with the 15-bed secure residential recovery component. In response to concern about cost and efficient use of resources, BGS developed additional analyses of the 3 site and cost options for this facility. In late August and again in November 2008, DMH and BGS staff and architectural consultants met with legislators to review current floor plan sketches and construction cost estimates.

A significant cost item for all options is the decision whether to have individual patient rooms and bath rooms (a standard for new construction for hospitals generally, and important for provision of trauma-informed environmental planning in mental health facilities). Another is whether to invest in minimal renovation to the current Brooks Rehab Unit and convert the current facility into the 15-bed secure residential recovery program. A draw-back of all rehabilitation proposals for the Brooks building is the need to relocate patients during construction. (Patient relocation is estimated to cost an addition $1 M and delay beginning of construction to 2015.) Both the Dale and Brooks renovations ---because they require the use of 2 floors to achieve the desired program of

space --- will require more staff than a one floor design and, consequently, an enhanced operational budget of approximately $500,000.

Following review of the architectural and cost documents and discussion with legislators about the trade-offs involved among the various site options, the administration is recommending new construction of a single bedroom, individual bath facility in the State Office Complex in Waterbury.

2.10 Select configuration & sites for detailed analysis for CON Application.

This task is in process.

BGS and DMH and their respective consultants developed architectural sketches, construction cost and financing estimates for the various proposed options for the 15-bed secure residential facility in Waterbury (including the Dale Building and a second, alternative renovation proposal for Brooks. See Objective 2.6 above). After consulting with the legislature the administration is proposing the new construction option. Development of detailed design documents for submission with the Phase II CON application awaits approval by the legislature to expend the funds reserved for completion of this phase of planning. (DMH has requested approval to expend $500,000. See Project Overview, p 4 above.) DMH expects to file the letter of intent for the CON application on or before November 1, 2009.

Conversations are currently underway with RRMC and Fletcher Allen Health Care Health Care to determine feasibility of inpatient unit expansion at these hospitals. The State has developed draft Principles of Collaboration (submitted with the October 2008 Report) with RRMC to develop approximately 12 VSH-level acute inpatient psychiatric beds as part of a proposed expansion of its psychiatric unit to 25 – 28 beds. DMH has also requested that Fletcher Allen Health Care Health Care include additional 16-20 VSH level beds in its Master Plan. In addition, the Department is reviewing options for developing additional beds at the Brattleboro Retreat.

Given the exigencies of the planning process, the Department submitted on March 25, 2009, a formal request for an 18-month amendment to or an extension of the Conceptual Certificate of Need in order to complete the final phase of planning. BISHCA, as noted (p.5 above), granted a 12 month extension to April 12, 2010.

Following is the current status of these planning activities:

Brattleboro Retreat
The Retreat has consistently collaborated with the State for psychiatric inpatient care. The Brattleboro Retreat is the only children's psychiatric inpatient program in Vermont and operates the largest adult inpatient program (except for VSH). However, use of the Retreat to replace a significant number of VSH –level psychiatric inpatient beds has the following limitations.

- Placing a major new inpatient capacity in Brattleboro would disrupt equitable geographic access to care. The preponderance of admissions to VSH are from Northern Vermont.
- Brattleboro Retreat, as a stand-alone psychiatric hospital, is only able to participate in the Medicaid Medicare programs based on a Waiver of Federal rules. Such a waiver is discretionary
- The Retreat does secure medical services from Brattleboro Memorial Hospital, but it does not offer the advantages of physical integration with medical center services.
- Many of the buildings at the Brattleboro Retreat are older than the physical plant of the Vermont State Hospital.

DMH and the Brattleboro Retreat currently have an agreement by which the State can secure "overflow" adult inpatient care from the Retreat on an as-needed basis. DMH anticipates continuing this arrangement. In addition, the Retreat in partnership with Health Care and Rehabilitative Services of Southeastern Vermont, is proposing to develop a new six-bed staff secure recovery residence designed to serve Vermonters currently at VSH.

Rutland Regional Medical Center

Rutland Regional Medical Center (RRMC) and the State have explored options to expand the existing capacity of the Rutland hospital's psychiatric inpatient program. RRMC has demonstrated serious interest in a collaboration agreement that details ownership and programmatic operations of a potential new program, roles and responsibilities during the planning phases, and an overall framework for capital development and operating cost. Although not concluded, these negotiations have progressed positively. In light of this, both DMH and RRMC are moving forward with continued project planning. Pending legislative action on the proposed Capital Bill for FY 10, DMH anticipates being a co-applicant on a letter of intent for a CON application for an expansion and enhancement of the psychiatric inpatient program at Rutland Regional Medical Center on or before June 1, 2010.

RRMC Current Program

Although the RRMC current psychiatric inpatient program is licensed for 19 beds, the floor plan limits the viable use to fewer than 19 beds at any given time. RRMC takes voluntary and involuntary patients. It is also a site for secure forensic evaluations provided the patient meets medical necessity criteria for hospital-level care. The current physical footprint of the service offers little treatment and program space, and only limited access to the outdoors. In the last two years RRMC has recruited outstanding clinical leadership and the program currently operates close to the 14-beds with positive reviews from consumers and family members who use the program. A multi-stakeholder community advisory council meets regularly with hospital leadership concerning the potential of expanding the program.

RRMC Proposed Expansion

DMH and RRMC first evaluated expanding the existing program into a neighboring unit and renovating the new, larger floor plan. This option had significant limitations including limited outdoor access, poor lines of sight from the nursing station, and constrained space that limits treatment options. Stakeholders raised several key concerns about the viability of the proposed space. In addition, it required re-locating an existing adjacent service.

A second option, new construction adjacent to the RRMC Emergency Department, appears to be more viable. The State and RRMC have modeled the development of a new, twenty-five bed program with the capacity for three residential sub clusters and ample program and treatment space. The estimated cost for such development is $25M.

The proposed capacity will operate as a single program. The staffing and programmatic design will serve the most acute and behaviorally challenging patient while providing access to the full range of medical center services. The program will be owned and operated by RRMC and will be able to receive insurances, Medicare and Medicaid reimbursement for services. The State will pay for remaining patient care costs for this population (that otherwise would have to be admitted to VSH) through an established rate structure to be negotiated. The State and RRMC are currently exploring the potential of targeting approximately 12-beds for VSH level care. Based on past utilization, it appears there is more than sufficient need to fully use the remaining 12-beds of the new facility.

Capital Development and Operating Costs

The State and RRMC are currently exploring options to capitalize the development of the proposed program. The State is proposing a special designation status for the RRMC program, similar to the designated status of the Community Mental Health Center network. In such a framework the State will secure the needed services and RRMC could be assured of consistent annual contracts provided that program performance targets are met.

If VSH were down-sized commensurate with the new capacity created at RRMC, then resources could be re-deployed from VSH to support the operation of the new program. The core issue is downsizing VSH in sufficiently large increments to free up the required resources. A possible scenario would time implementation of the RRMC expansion and the DMH proposed 15-bed secure residential recovery program to converge such that VSH could be downsized to a licensed bed capacity of 16. In this configuration, the 16-bed VSH, the 15-bed Secure Recovery Residence, and the 12-bed expansion at RRMC would all be eligible for Medicaid reimbursement in addition to any other insurances. The current VSH allocation, combined with federal financial participation (FFP), would support the operations of all three programs into the future.

Legislative Action and Next Steps

Consistent with previous capital appropriations, DMH requests capital funds of $250,000 in FY 2010 to continue project development for Certificate of Need (CON) review. In addition, consistent with previous legislative action and reports[1], DMH and RRMC request continued policy support for this partnership to provide acute inpatient psychiatric services that were previously carried out at Vermont State Hospital.

If the Capital Bill is approved, the next step will be for RRMC, with support from DMH, to seek CON review during the summer of 2010 for the proposed new construction and programmatic expansion. Only if a CON is granted could the project go forward into the permitting, bonding and construction stages.

2.11 Obtain BISHCA guidance re: sequencing of CON application.

This task is on-going.

2.12 Develop and submit CON Application

Per BISHCA 's March 31, 2009 extension of the Conceptual Certificate of Need, DMH will submit a letter of intent to apply for a Certificate of Need for the 15-bed secure residential recovery facility in Waterbury on or before November 1, 2009. The Department anticipates being a co-applicant on a letter of intent for a CON application for an enhanced inpatient psychiatric program at Rutland Regional Medical Center on or before June 1, 2010.

Benchmark Objective 3: **Assure mental health consumer & stakeholder participation (CCON Condition 19)**

Activities under this Objective are on-going.

3.1 Establish Transformation Council

This task has been completed.
Beginning in September 2007 the Commissioner of Mental Health has conducted regular monthly meetings with the Transformation Council to review, discuss, and provide input on the various policy initiatives of the Futures Project. The composition of the Council includes advocates, providers, and clients and family members. Attendance generally numbers between 20 – 30 individuals. The following items were discussed during meetings held October 2008 – April 2009:

[1] Consistent with Vermont State Hospital Futures Plan ("the Plan") required by Sec. 141a of No. 122 of the Acts of the 2003 Adj. Sess. (2004), as approved by the Joint Mental Health Oversight Committee on March 22, 2006, and by the Joint Fiscal Committee on April 25, 2006; of the FY 2006 Appropriation Bill Sec. 113e; the Vermont Legislature's Consulting Group on the Future of VSH and Systems of Care: Final Report to the Committee on Committees of the Senate and the Speaker of the House, November 9, 2007; and the Capital Acts of 2005, 2006, and 2009.

- Status of Vermont State Hospital's certification issues with the Center for Medicare and Medicaid Services
- The State's budget situation and its impact on mental health programs
- The proposed 15-bed secure residential recovery facility (SRR) and the inpatient beds proposed for Rutland Regional Medical Center
- Changes in VSH Governing Body
- Status of program development for peer alternative crisis housing
- Status of program development for the 6-bed staff secure residential facility
- Cumulative impact of budget cuts on program service recipients
- Preliminary planning efforts for treatment programming at the SRR; planning to obtain input from current and former VSH patients and family members
- Discussion around proposed legislation: inclusion of mental health coverage in workers compensation; determination of informed consent
- Proposed state personnel actions in response to FY10 budget deficits
- VSH staffing issues when there is high census of patients requiring 1:1 coverage
- Status of the Care Management Project
- NAMI's grading of the States 2009

3.2 Post planning documents & meeting minutes on DMH website
http://healthvermont.gov/mh/update/mhupdate.aspx

This task is on-going. See website.

3.3 Maintain active outreach to communities impacted by planning for, development of inpatient & community facility sites; convene work groups as needed for input to program planning processes.

This task is on-going. Recent examples include the extensive planning process for the care management system design. See Objective 10.4.

3.4 Provide updates to and solicit feedback from State Mental Health Adult Program Standing Committee

This task is on-going.

This 6 member group meets monthly and receives regular updates on the Futures Project.

3.5 Copy Interested Parties as required by BISHCA CON process

This task is on-going.

Note: Other activities to enhance mental health consumer and stakeholder participation include the bi-weekly distribution of the Mental Health Update to a 400 member e-mail group. Meeting minutes and planning documents are regularly posted on the Department's website: http://healthvermont.gov/mh/update/mhupdate.aspx

Benchmark Objective 4: Develop program design for new levels of care for VSH patients & DOC inmates needing acute inpatient care (with outside review). (CCON Scope #2,6,7,26, CCON Condition 14)

Benchmark tasks 4.1 – 4.4 (Work Group review reports, identify inpatient needs, update & refine descriptions of populations served)

Tasks have been completed.

The Futures project is based on the premise that Department of Corrections inmates who are mentally ill should have access to psychiatric hospitalization on par with that available to the general population; further, that the same standards of treatment should apply.

A Department of Mental Health work group met during the summer and fall of 2007 to review the issues of inpatient mental health services for Corrections clients, specifically the inpatient psychiatric bed needs of the DOC population. A clinical assessment of the inpatient psychiatric bed needs of Corrections' inmates concluded that between 2 and 4 inpatient beds would be required to meet DOC inpatient needs. The analysis and findings of this report will be incorporated in the inpatient CON application documentation.

Benchmark Tasks 4.5 – 4.8
Note: The time lines for achievement of these tasks have advanced in conformity with revisions of the anticipated CON application date. (See Work Plan)

4.5 Develop program goals & treatment methods sufficient to establish cost and operational parameters for CON Application.

This task is in process and will be completed in detail sufficient for the purposes of the CON application at time of the filing of the Application for the 15-bed SRR. Per BISHCA's extension of the CCON, the letter of intent for this project is now anticipated to be filed on or before November 1, 2009. Program planning for the RRMC CON application is expected to result in the filing of a letter of intent or before June 1, 2010.

4.6 Develop staffing model & plan sufficient to establish cost and operational parameters for CON Application (CCON Scope # 20, Condition 18)

This task for the SRR is in process and will be complete at time of the Phase II CON Application, now anticipated in December 2009. The planning for the RRMC CON application will be complete at the time of the proposed application Summer 2010.

4.7 Obtain outside review of program model for appropriateness for populations to be served, conformity with accreditation standards, cost effectiveness of service. (CCON Scope #7)

This task has begun. A contract was let to Amanda Goza, Ph.D., psychological consultant, to develop a preliminary conceptual draft of the proposed programming for the 15-bed SRR. The initial draft of this document will become a working document that will develop in response to stakeholder comment. It is anticipated that consumers (including current patients at VSH), family members and advocates, as well as providers, will be asked to provide feedback and suggestions during the period prior to DMH filing its letter of intent for the CON application (now expected to occur on or before November 1, 2009). Similar program content will be developed consistent with the proposed CON application for the renovation of the RRMC psychiatric facility.

4.8 Refine architectural program of space requirements as needed (CCON Scope # 9, 10)

This task is in process for the 15-bed SRR and will be complete at the time of the CON Application. It is anticipated that consumers (including current patients at VSH), family members and advocates, as well as providers, will be asked to provide feedback and suggestions during the period prior to the filing of the letter of intent for the CON application. Similar refinements to the architectural program of space will occur consistent with the timeline for the proposed CON application for the renovation of the RRMC psychiatric facility (Summer 2010).

4.9 Review programming plans with Transformation Council, Adult Program Standing Committee, other stakeholders, Legislature, BISHCA.

This task is on-going. See above (2.5, 2.6, and 3.1)

Benchmark Objective 5: Develop architectural, site & construction plans for most feasible option(s) demonstrating conformity with relevant CON criteria. (CCON Conditions 15,17)

Benchmark Tasks 5.1 – 5.3 (Complete Architectural Program of Space, Identify Alternative Sites, Analyze Alternative Sites)
In process. See Work Plan. Detailed architectural site plans, analyses and cost estimates will be presented at the time of the CON application for the 15-bed SRR, now anticipated to occur in December 2009.

Benchmark Objective 6: Identify and plan to mitigate human services impacts of potential selected sites (CCON Specifications 14,29,32)

Tasks 6.1 – 6.4, 6.6, 6.7 (Identify VSH discharge patterns, consult local community, assess human service impacts of program, hold public meetings, consult with Transformation Council, other interested parties, develop & implement strategies to address impacts, etc.)

These tasks await identification and final selection of inpatient sites of the preferred configuration. DMH and RRMC will hold public meetings as indicated and develop and implement strategies to address impacts of the proposed enhancements to their facility.

Similar meetings and strategies appropriate to other locations will be implemented, once it becomes clear where the new inpatient facilities will be located. Impact assessment and meetings will also be held in Waterbury around planning for the 15-bed SRR.

Benchmark Objective 7: Develop long-range financing plan that reflects balance between inpatient services & community system of care. (CCON Scope #8,12,27; CCON Condition 15,17)

Benchmark Tasks 7.1 – 7.4 are completed for the initial Draft Inpatient Options Analysis sites. Pending legislative approval to expend Phase II planning funds (and per BISHCA extension of the CCON), the second iteration of the planning process to develop capital cost estimates for the 15-bed SRR and the enhanced psychiatric facility at RRMC will proceed..

Benchmark Tasks 7.5 – 7.8 (obtain consultation from BISHCA, develop draft operating financing plan, draft capital construction plan, develop 5 year financing plan, etc.)

These tasks await legislative approval to expend Phase II planning funds. The plans will be completed at time of Certificate of Need Application.

The September 2007 Pacific Health Policy Group Final Report, *Follow-up Study on the Financial Sustainability of the Vermont Designated Agency Provider System for Mental Health, Developmental Disability and Substance Abuse Services,* found that mental health caseload demand is increasing as is the intensity of service need. This is resulting in a growth of demand that is outpacing the growth in General Fund receipts at the rate of 9% per year. At this rate of acceleration the current system is not sustainable. AHS and the Department are currently in the process of developing a strategic plan to address this reality. This planning process has been complicated by the current economic crisis.

These contextual factors underline the clear risk of overbuilding expensive acute care beds and lend support to phased implementation of VSH successor programs. It will be important to phase Futures implementation and do specific projects first. As a consequence of differing sites, licensing entities, revenue potential and capital development costs, each project site will require its own financing package.

As new community resources are implemented, the Department continues to monitor impact on the VSH census. Stabilization of the trend line (and further evaluation of bed needs in terms of specific requirements of various patient groups) will enhance long range financial planning to promote balance between inpatient and community services.

Benchmark Task 7.9 (review with Stakeholders)
This task is on-going.

Benchmark Task 7.10 (review draft financing plan at completion of design & documents preparation process, etc.)

This task awaits selection of final sites and completion of schematic design, design development and permitting planning documents. It is anticipated that these documents will be submitted at the time of the 15-bed SRR CON application (December 2009) and the RRMC psychiatric facility application (Summer 2010).

Benchmark Objective 8: **Develop partner agreements for planning, construction & facility operations (CCON Condition 17,18)**

Note: The timelines for the various tasks under this benchmark have been adjusted to conform with revised planning timelines for the CON application.

RRMC and the State are currently exploring a collaboration agreement that details ownership and programmatic operations of a potential new program, roles and responsibilities during the planning phases, and an overall framework for capital development and operating costs. Although not concluded, these negotiations have progressed positively and in light of this, both DMH and RRMC are moving forward with continued project development. Pending legislative action on the proposed Capital Bill for 2010, DMH anticipates being a co-applicant on a letter of intent for a CON application for an expansion and enhancement of the psychiatric inpatient program at Rutland Regional Medical Center on or before June 1, 2010. See Objective 2.10 above.

Benchmark Task 8.1 Obtain clarification from BISHCA re: CON standards for partner agreement.
Task is on-going. Content currently informs discussion with potential hospital partners.

Benchmark Tasks 8.2 – 8.5 (Potential partner agreements)

Since the October Report DMH has proceeded with joint planning to develop VSH level inpatient capacity at RRMC. Conversations with Fletcher Allen Health Care Health Care continue. DMH is also in discussion with Dartmouth-Hitchcock Medical Center to explore ways to provide inpatient psychiatric services to replace the last of the VSH psychiatric beds that would remain following construction of the SRR and the enhanced psychiatric unit at RRMC. Conversations continue at the writing of this report.

Benchmark Task 8.6 (Development of agreements for staffing, workforce development, etc.)

This task will be addressed as part of the planning between DMH and its partner organization(s) in anticipation of the CON application(s).

Benchmark Task 8.7 (Consult Transformation Council, Adult Mental Health Program Standing Committee, Legislators, BISHCA)

This task is on-going.

Benchmark Objective 9: Develop workforce recruitment & retention plans to adequately & appropriately support new inpatient programs. (CCON Condition 18)

Work on this Objective and tasks related to inpatient psychiatric services will begin once DMH completes agreements with its potential hospital partners. Work on these tasks as they relate to staffing the 15 bed secure residential, staff secure and community residential programs is in process. Time lines will be revised as planning proceeds.

Benchmark Task 9, 7 (Obtain input from VSEA, other players and stakeholders, etc.) will be initiated around work-force development once program planning parameters are more completely worked out.

Benchmark Objective 10.1 – 10.6: Develop community capacities (CCON Scope #15,16,17,18,24,25,29)

Benchmark Objective 10.1 Increase community residential recovery, and secure and non-secure levels of rehabilitation beds (23 beds):

In process. See Objective 2.2 above.

Community residential recovery
During summer 2008 the Second Spring program in Williamstown expanded its capacity from 11 to 14 beds.

The Department is currently reviewing a Certificate of Approval from *New Perspectives for Care* (formerly called the Southern Alliance, a consortia between HCRS and the Brattleboro Retreat) to develop a 6-bed staff secure recovery residence in the Brattleboro area. This program would be operated as a joint venture between HCRS and the Brattleboro Retreat under the aegis of New Perspectives for Care. During the past several months, staff from New Perspectives for Care have met with VSH staff to identify the treatment needs of potential residents and identify appropriate (evidence-based) program models. If this effort proves successful it is expected that the facility would open during 2009. With the additional beds at Second Spring and the development of 6 beds in the staff secure facility (named Meadowview) the number of community residential beds would increase to 20.

Benchmark Objective 10.2 Increase crisis stabilization beds (10 beds): program start-up for 4 beds (NEKHS - NCSS) plus 6 additional beds

Since the April Implementation Report, 6 planned additional crisis beds have come on line. The number of adult crisis beds statewide is listed below:

- Assist Program - HowardCenter, Burlington (5 beds)
- C.A.R.E. Bed Program - NEK, St Johnsbury (2 beds)
- Bayview Program - NCSS, St Albans (2 beds)

- Crisis Stabilization Inpt Diversion Program (CSID) - RMHS, Rutland (2 beds)
- Home Intervention - WCMH, Montpelier (4 beds)
- Battelle House - UCS, Bennington (6 beds)
- Alternatives - HCRS, Springfield (4 beds)

As new residential and crisis bed capacity comes online, the Department monitors their impact on VSH admissions and inpatient census. The current total statewide crisis bed capacity is 25 beds.

Updating the Transformation Council and other stakeholder groups is ongoing.

Benchmark Objective 10.3 Develop Peer Services program plan

This task is in process.

During FY09 the Department appropriated $247,536 for peer crisis respite services. Through an RFP process, a project director was selected to develop a Peer-Run Crisis Alternative House. Initial tasks include finding a location for the program. The complexity of the task has presented challenges that have resulted in a somewhat slower than hoped for planning process. It is expected that initial draft program and facilities plans will be formulated during 2009 with initial program implementation beginning in late fall/winter 2009 / 2010.

Benchmark Objective 10.4 Design Care Management System (CCON Scope #28)

This task is in process.

The development of a care management system based on real time knowledge of bed availability and common decision support protocols and rules by which patients may move through the system is a key part of Futures Project planning. The FY09 appropriation contained funds for consultation services. The Department contracted with the University of New England / Center for Health Policy, Planning and Research to assess the Vermont service delivery network and provide clinical design services for a Care Management System. The draft report is expected to be circulated for discussion and review in April 2009. Next steps in the discussion and implementation process include:

- Exploration of how to create a participatory process for program and system development that is representative of the various stakeholder entities
- Developing a process involving hospital emergency department directors, hospital psychiatric units, emergency services workers and local crisis stabilization programs that will result in individuals who are undergoing an emergency psychiatric crisis after hours being safely housed overnight; and a guaranteed next day process among the clinical representatives from all potential admitting facilities that will result in appropriate inpatient hospitalization for the required

treatment
- Developing a real-time information system on bed availability that is state wide
- Using Level of Care Utilization Scale (LOCUS) as a conceptual framework to achieve common definitions of the function and services provided by the respective entities that comprise the mental health delivery system. The intent is to achieve a reasonable degree of standardization of definitions of services to support the decision processes that match individual patients with the appropriate treatment program.

Benchmark Objective 10.5 Increase housing resources (CCON Scope #17, 29)

As reported in September planning tasks A,B,C have been completed (See Work Plan)

With input from the VSH Futures Housing Development Work Group, final recommendations of the VSH Futures Advisory Committee, and interested stakeholder participation, the Department of Mental Health distributed the FY 08 recovery housing funds of $460,500 by allocating one half equally among the ten Designated Agencies. The remaining one half was distributed using Designated Agency hospital utilization rates for FY07. The FY 09 appropriation for housing is $492,072 and has been similarly distributed. These funds, by supporting longer term housing arrangements in the community, make it possible for individuals who are ready for discharge to leave transitional community residential care programs, and thus expedite the flow of patients through the system.

Task element "E" –Assess impact of additional housing on inpatient bed need & design is in process.

Task elements "F" --- identify need, create development fund plan --- is being coordinated by the AHS Housing Task Force (the state's policy group charged with developing permanent supportive housing for people with disabilities). It is anticipated that Vermont will have opportunity under the federal stimulus distribution to leverage additional housing funds.

Updating of the Transformation Council, State Adult Mental Health Standing Committee and other stakeholders for consumer, family, and advocates' feedback is ongoing.

Benchmark Objective 10.6 Develop alternative transportation system

Tasks A and B have been achieved. The alternative involuntary transportation pilot operated by HowardCenter and Washington County Mental Health began in September 2007 and continues to operate. DMH issued a report to the Legislature, *Transportation of Individuals in the Custody of the Commissioner of Mental Health* (January 15, 2009) as required by 18 VSA § 7511 that provides the data on secure transports for the preceding year. Program evaluation is expected in June 2009.

Material or Non-material Changes

There are no material changes in this CON process. All activities described above that have been undertaken since the granting of the April 2007 Conceptual Certificate of Need are authorized under the scope of the approved planning activities.

Attachments

1. Architectural Planning Appropriations, Encumbrances and Expenditures – April 8, 2008
2. PHPG expenses
3. Amanda Goza consultation expenses
4. New England Center for Health Policy, Planning and Research consultation expenses
5. VPS contract for program development services for peer alternative